CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION TO CHANGE FROM PHYSICIAN MD/DO TO ADMINISTRATIVE MEDICAL LICENSE
INSTRUCTION SHEET

When to File

An Administrative Medical license allows physicians to use their medical and clinical knowledge, skill, and judgment ***only*** in an administrative capacity.

File this application when you are a physician practicing administrative medicine When you hold an Administrative Medical license, you are not allowed to provide any of the following medical or clinical services:

- examine, care for or treat patients
- prescribe medications including controlled substances
- delegate medical acts or prescriptive authority to others

File this form if you wish to change your ***active*** Delaware Physician MD or DO license to an Administrative Medical license. When you change to an Administrative Medical license, you relinquish your Delaware Physician MD or DO license.

Requirements

☐ Submit a completed, signed and notarized *Request to Change to Administrative Medical License* form.

☐ Enclose Change to Administrative Medical fee by check or money order made payable to "State of Delaware."

☐ If you *ever* held a medical or training license in any jurisdiction other than Delaware, a license verification from *each* jurisdiction where you have held a license is required. However, you will submit some verifications with this form, while others will come directly from the jurisdiction to the Board office. ***Read the following information about requesting verifications carefully:***

- If a jurisdiction utilizes VeriDoc to process license verifications, you must request the verification from VeriDoc, not from the jurisdiction. VeriDoc will send the verification directly to the Board office, not to you. For a list, click VeriDoc Participating States.
- If you have ever held an Indiana license, request a digitally-certified verification at http://www.in.gov/pla/verify.htm. The site will download a verification in pdf format to your computer. Print the pdf document and send it in your packet. Contrary to the instruction on Indiana's site, please do *not* email the pdf document to the Board office unless the Board office asks you to do so.
- For all other jurisdictions, request the jurisdiction to send the verification to you and enclose it with your form.
  - You may use the *Verification of Physician License* form included with this application form to request the verification.
  - You may wish to obtain an AMA Profile or AOA Profile in order to make sure that you request verifications of all licenses that you have ever held.
  - Before requesting a verification, check whether the jurisdiction requires a fee.
  - The jurisdiction's seal must be affixed to the form.
  - Remember to enclose the envelope in which you received the verification from the third party source.
- Verifications that you print off the internet or receive by fax will not be accepted.

☐ If you answer "yes" to questions in the DISCLOSURES section – other than Questions 18, 20, 21 – you must fully explain your answer. We suggest that you use the *Physician Self-Report* form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, submit a *signed, notarized statement* in lieu of or in addition to the *Physician Self-Report*.

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION TO CHANGE FROM PHYSICIAN MD/DO TO ADMINISTRATIVE MEDICAL LICENSE

IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____ _____ _____
   Last/Family First Middle

2. Enter Delaware Physician MD/DO license number: license number C__-_____

3. Mailing Address: _____

   _____ _____ _____
   City State Zip

4. Phone: _____ _____ Email: _____
   Home or cell Work

LICENSURE HISTORY

5. Have you ever held a medical license issued by another jurisdiction (state, U.S. territory or District of Columbia)? Yes ☐ No ☐ If yes, list *each* jurisdiction where you now hold, or have *ever* held, a medical license, including training licenses. If you need more room, enclose an additional sheet with the same information.

JURISDICTION	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE

A license verification from *each* jurisdiction where you have held a license is required. *See the Instruction Sheet for details on how to submit license verifications.*

CERTIFICATION OF ADMINISTRATIVE MEDICAL PRACTICE

6. To obtain an Administrative Medical license in Delaware, you must certify that you understand that you are ***not*** allowed to provide medical or clinical services.

   I certify that I have read 24 *Del. C.* §1720(j) and that I understand I may ***not*** provide medical or clinical services to or for patients. Yes ☐ No ☐

DISCLOSURES

If you answer "yes" to questions in this section – other than Questions 18, 20, 21 – you must fully explain your answer. We suggest that you use the *Physician Self-Report* form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, submit a signed, notarized statement in lieu of or in addition the *Physician Self-Report*. Specify the jurisdiction where the incident occurred, the issues involved and any further information you wish to provide.

7. Have you ever been professionally penalized or convicted of fraud? Yes ☐ No ☐

8. Have you ever had a medical or professional license denied or revoked? Yes ☐ No ☐

9. Have you ever violated the Medical Practice Act of another jurisdiction? Yes ☐ No ☐

10. Have you ever been disciplined or had formal written action taken by a hospital staff or medical society, or licensing board of another jurisdiction? ***Your response should include any discipline or action taken during your training program including, but not limited to, academic probation.*** Yes ☐ No ☐

11. Has a hospital, related health care facility, HMO, or alternative health care system ever:
    - denied your application for privileges or failed to renew your privileges? Yes ☐ No ☐
    - limited, restricted, suspended, or revoked your privileges in any way (including during your training program)? Yes ☐ No ☐

12. Have you ever been the subject of an investigation by a licensing authority, medical association, hospital or other healthcare institution? Yes ☐ No ☐ **If yes, provide a copy of any documents in your possession related to the final disposition of the investigation and continue with the next question. *If no, skip to Question 14*.**

13. Do you agree to sign an authorization for the Board of Medical Licensure and Discipline and the Division of Professional Regulation to obtain any and all information concerning the disposition of the investigation directly from the licensing authority, medical association, hospital or other healthcare institution? Yes ☐ No ☐

14. Have any charges or complaints of any kind, such as malpractice claims, ever been filed against you? (Include any that are *currently* pending against you.) Yes ☐ No ☐

15. Have you ever engaged in the practice of medicine without a license? Yes ☐ No ☐

16. Have you ever willfully violated the confidence of a patient? Yes ☐ No ☐

17. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any of the following:
    - administrative or judicial proceedings or investigation? Yes ☐ No ☐
    - inquiry or other proceeding? Yes ☐ No ☐
    - proposed termination by an educational institution, employer, governmental agency, professional organization, or licensing authority? Yes ☐ No ☐

    If yes to ***any*** item, continue with the next question. **If no to *all*, skip to Question 19.**

18. Are such current conditions or impairments reduced or ameliorated because of ongoing treatment (with or without medication) or participation in a monitoring program or because of the field of practice, the setting, or the manner in which you have chosen to practice medicine? Yes ☐ No ☐

19. Do you have a mental or physical disability that limits your ability to practice medicine in a fully competent and professional manner with safety to patients? Yes ☐ No ☐ **If yes, continue with the next question. If no, skip to Question 21.**

20. Are you willing to accept a conditional or limited license to practice medicine if it is possible to accommodate such disability? Yes ☐ No ☐

21. Do you agree to submit to an examination at your own expense if the Executive Director of the Board of Medical Licensure and Discipline deems it necessary to determine whether your physical and/or mental impairment presents a significant risk to the health or safety of patients or otherwise causes you not to be fully qualified to practice medicine in a competent and professional manner with safety to patients without limitations or accommodations? Yes ☐ No ☐ **If no, submit a signed, notarized statement fully explaining your answer.**

DUTY TO REPORT

22. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report*. Yes ☐ No ☐

23. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

24. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to self report all of the following:
    - Any change in hospital privileges and any disciplinary action taken by any medical society against you within 30 days (24 *Del. C.* §1730(b)(1))
    - Any civil or criminal investigation in any jurisdiction which concerns your certification or license or other authorization to practice medicine within 30 days (24 *Del. C.* §1730(b)(2))
    - All information concerning medical malpractice claims settled or adjudicated to final judgment, as provided in Chapter 68 of Title 18, within 60 days. (24 *Del. C.* §1730 (c))
    - Each final judgment, settlement, or award against you regardless whether you have malpractice insurance, within 30 days of the final judgment, settlement, or award. (24 *Del. C.* §1731A (f))
    - Any reports filed against you with the Department of Services for Children, Youth and Their Families under Chapter 9 of Title 16 concerning child abuse or neglect (24 *Del. C.* §1730 (d))
    - Any reports filed against you to the Division of Long Term Care Residents Protection under Chapter 85 of Title 11 concerning adult abuse, neglect, mistreatment or financial exploitation (24 *Del. C.* §1730 (d))

    I certify that I have read and understand all of provisions in the Delaware Medical Practice Act, including those listed above, and understand my *duty to self report*. Yes ☐ No ☐

Continued on next page

AFFIDAVIT

I swear all of the following:

- I am the person who executed this application.
- The statements contained on this application are true in every respect.
- I have not suppressed or withheld information that might affect this application.
- I will abide by the laws and the ethical standards of this profession.
- I have read and understand this statement.

I hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine whether I have previously engaged in unprofessional conduct as defined in 24 *Del. C.* §1731 or the Rules and Regulations of the Delaware Board of Medical Licensure and Discipline and to determine that I am physically and mentally capable of engaging in the practice of medicine with safety to the public.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Delaware Board of Medical Licensure and Discipline any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or other pertinent data and to permit the Delaware Board of Medical Licensure and Discipline or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

I understand and acknowledge that the Delaware Board of Medical Licensure and Discipline will rely on the information I have provided in this application in making its determination on licensure. I hereby expressly agree to

- Keep the information in this application current until such time as the Board has finally acted on it, and
- Promptly provide any and all additional information requested by or on behalf of the Board.

Signature of Applicant: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Signature of Notary: _____

SEAL

My Commission Expires: _____

REQUESTS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

VERIFICATION OF PHYSICIAN LICENSE

Instructions to Applicant: You may use this form to obtain a license verification from each jurisdiction where you have ever held a license to practice medicine or administrative medicine. Do not use this form for VeriDoc participating jurisdictions or Indiana verifications. Submit all forms in your application packet *together with the envelopes in which you received each form*.

Licensing Authority:_____ Address:_____ City/State/Zip: _____	Applicant Name: _____ Home Address: _____ City/State/Zip: _____

This section to be completed by Applicant	Last Name:_____ First:_____ Middle: _____ SSN:_____ DOB:_____ Other Name(s) Used: _____ License Number(s) in Jurisdiction Named Above: _____ **I am applying for an Administrative Medical License in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to the Delaware Board of Medical Licensure and Discipline.** This includes any medical training licenses. **Applicant Signature:** _____ Date: _____
This section to be completed by Licensing Authority	Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of _____ License Number: _____ Issue Date (month/day/year): _____ Expiration Date (month/day/year): _____ Has any discipline activity taken place regarding this licensee? Yes ☐ No ☐ **If yes, please enclose a certified copy of the Board Order with this license verification.**
CERTIFICATION AFFIX OFFICIAL SEAL OR NOTARY HERE	**Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.** **Printed Name of Official:** _____ **Signature of Official:** _____ **Date:** _____ **Title:** _____ **Phone:** _____ **Fax:** _____ **Email:**_____

***Mail* (do not fax) completed, signed and sealed form to the applicant above.**

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

PHYSICIAN SELF-REPORT FORM

The Physician's mandatory duty to self-report is in 24 *Del C.* § 1730 and § 1731A. To comply with your duty, complete and submit this form to the Board of Medical Licensure and Discipline within the required time limit. You may duplicate the form.

IDENTIFYING AND CONTACT INFORMATION

1. Physician Name: _____ _____ _____
   Last First Middle
2. Delaware License Number: C ___ - _____
3. Mailing Address: _____
   _____ _____ _____
   City State Zip
4. Office Phone: _____ Email: _____

MALPRACTICE COMPLAINT

5. Plaintiff Name: _____ Age: _____ Sex: _____
6. Address of Record: _____
7. Date of Occurrence: _____
8. Place of Occurrence (office, hospital name & address): _____
9. What was your position in case (e.g., resident, primary physician)? _____
10. Who was the complaint filed against? ☐ Individual Doctor ☐ Group ☐ Hospital
11. Names of other defendant-doctors and/or hospitals: _____
    _____

DISPOSITION

12. What was the disposition? ☐ Verdict ☐ Settled
13. Final Disposition: _____ Date: _____
14. Civil Case No.: _____ Attorney: _____
15. Total Amount Paid (if any): _____
16. Amount Attributable to You: _____
17. Insurance Company Covering You for this Incident: _____

Signature: _____Date: _____

You may attach a detailed explanation of the medical issues involved in the referenced litigation.